

9504

CERTIFICATE OF DEATH

10575

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Talbot Caroline | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | d. STREET ADDRESS 058-2 | |
| 3. NAME OF DECEASED (Type or print) First Viola Middle Griffith Last Brinsfield | | 4. DATE OF DEATH Month August Day 9 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 8, 1892 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Zorah Brinsfield | | 14. MOTHER'S MAIDEN NAME Agnes Pardoe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ukn. | |
| 17. INFORMANT Mrs. Mildred Douglas, Preston, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Melanoma of right breast 190.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 219 S. Westinghouse St. P. 10, Maryland DATE SIGNED May 58 ACTUAL SIGNATURE E. C. H. Schmidt PHYSICIAN'S NAME (Type) E. C. H. Schmidt | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/12/58 | 22c. NAME OF CEMETERY OR CREMATORY Union Grove Cemetery | 22d. LOCATION (City, town, or county) (State) Caroline County, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry M. Hollis, etc. | | 24a. REC'D BY REGISTRAR DATE P 17 '58 | |
| ADDRESS Preston, Md. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thoms | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2-05

| | | | |
|---|--|--|--|
| <p>1. Name of deceased: [illegible]</p> | | <p>2. Sex: [illegible]</p> | |
| <p>3. Date of birth: [illegible]</p> | | <p>4. Place of birth: [illegible]</p> | |
| <p>5. Date of death: [illegible]</p> | | <p>6. Place of death: [illegible]</p> | |
| <p>7. Cause of death: [illegible]</p> | | <p>8. Manner of death: [illegible]</p> | |
| <p>9. Signature of physician: [illegible]</p> | | <p>10. Signature of registrar: [illegible]</p> | |
| <p>11. Date of registration: [illegible]</p> | | <p>12. Place of registration: [illegible]</p> | |

9505

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> | c. LENGTH OF STAY IN 1b <i>2 hrs. 40 min</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i> <i>05x-2</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | d. STREET ADDRESS <i>212 N. 5th ST.</i> | |
| 3. NAME OF DECEASED (Type or print) First <i>Granville</i> Middle <i>Brown.</i> Last <i>Brown.</i> | | 4. DATE OF DEATH Month <i>August</i> Day <i>5</i> Year <i>1958</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>November 10, 1903</i> |
| 9. AGE (In years last birthday) <i>54</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plummer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Plummer</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Harvey Brown</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Elizabeth</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Palto</i> , 19 <i>1958</i> , to <i>1958</i> , that I last saw the deceased alive on <i>1958</i> and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>E.C.H. Schmidt</i> | | ADDRESS (Street, city or town, state) <i>219 S. Washington St. Easton 16 Maryland</i> | |
| PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i> | | DATE SIGNED <i>Aug 6, 1958</i> | |
| 22a. BURIAL, CREMATION, REMOVAL, SPOUL | 22b. DATE THEREOF <i>AUG. 10, 1958</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Spring Grove</i> | 22d. LOCATION (City, town, or county) (State) <i>Denton, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Brown</i> | | 24a. REC'D BY REGISTRAR DATE <i>AUG 8 '58</i> | 24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9506

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i> | | | | c. LENGTH OF STAY IN 1b <i>13 hrs.</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Wittman.</i> | | | |
| f. STREET ADDRESS <i>1</i> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Ruth</i> Middle <i>W</i> Last <i>Chapman</i> | | | | 4. DATE OF DEATH Month <i>August</i> Day <i>11</i> Year <i>1958</i> | | | |
| 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>W</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>June 29, 1891</i> | |
| 9. AGE (In years last birthday) <i>67 yrs.</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 11. BIRTHPLACE (State or foreign country) <i>Indian a</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Dr. Kent Wheelock.</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Matilda Henderson.</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>none</i> | | 17. INFORMANT <i>J. Halbrook Chapman Wittman Md.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Myocardial infarction due</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ischemic coronary thrombosis</i> DUE TO (c) <i>14 hrs.</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <i>19</i> Month <i>8</i> Day <i>11</i> Year <i>1958</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>8/11</i> , 19 <i>58</i> , to <i>8/11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/11</i> , 19 <i>58</i> , and that death occurred at <i>4:55 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Thorston Harrison</i> | | | | ADDRESS (Street, city or town, state) <i>Carlton Maryland</i> DATE SIGNED <i>12 Aug. 58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Aug 14, 58 Woodlawn Cemetery New Md.</i> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Carlton Md.</i> | | | | 24. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| | | | | DATE <i>Aug 13 '58</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|-----------------------|--|----------------------|--|------------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | |
| PLACE OF DEATH | | CITY | | COUNTY | | STATE | | ZIP CODE | |
| OCCUPATION | | EDUCATION | | MARRIAGE | | RELIGION | | CAUSE OF DEATH | |
| MANNER OF DEATH | | CERTIFICATE NO. | | REGISTERED | | FILED | | DATE | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESS | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF CLERK | | SIGNATURE OF JUDGE | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | | DATE OF SIGNATURE | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 13 Film 232 8-21-58 et
9507
CERTIFICATE OF DEATH

09500

Reg. Dist. No.

| | | | |
|--|---------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Ann</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17x2 ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>MINA</u> First <u>Covington</u> Middle <u>Covington</u> Last | | 4. DATE OF DEATH <u>8</u> Month <u>15</u> Day <u>19</u> Year <u>58</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-17-1891</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel Haddaway</u> | | 14. MOTHER'S MAIDEN NAME <u>Manie Frampton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> (?) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/19/58</u> 19 <u>58</u> , to <u>8/15</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8/14</u> 19 <u>58</u> , and that death occurred at <u>6:10</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D. <u>Arthur S. Kraus</u> PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u> <u>16 Aug 58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Moore</u> ADDRESS <u>Tyngman</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 19 58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

CERTIFICATE OF DEATH

Reg. Dist. No.

9508

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. LENGTH OF STAY IN 1b 16 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE MEMORIAL HOSPITAL | | | | d. STREET ADDRESS HARMONY | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First BELLE Middle - Last FOLS | | | | 4. DATE OF DEATH Month August Day 6 Year 1958 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 13, 1886 | |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY maryland | | | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JAMES KEMP | | | | 14. MOTHER'S MAIDEN NAME JENNIE M. FLEETWOOD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. - | | | |
| 17. INFORMANT CHARLIE FOLS, PRESTON, MD., RFD | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Pelvic thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pelvic thrombosis DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Granuloma pneumonia 1947 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) 219 S. Washington St. | | | | 20g. (County) Federalburg | | 20h. (State) MD. | |
| 21. I certify that I attended the deceased from Feb 1958 , 19 58 , to Aug 6, 1958 , that I last saw the deceased alive on Aug 6, 1958 , and that death occurred at 11 A. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE E. C. H. Schmidt | | | | DATE SIGNED Aug 14 1958 | | | |
| PHYSICIAN'S NAME (Type) E. C. H. Schmidt | | | | ADDRESS Easton 16, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF AUG. 9, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY | | 22d. LOCATION (City, town, or county) (State) FEDERALSBURG, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. J. Thompson | | | | ADDRESS Federalburg Md. | | 24. REGISTRAR'S SIGNATURE John S. Frank | |
| 24a. REC'D BY REGISTRAR AUG 14 1958 | | | | DATE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

9509

CERTIFICATE OF DEATH

Reg. Dist. No. 09502

| | | | | | | | |
|---|---------------------------|--|---------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Debbie</u> Middle <u>Ellen</u> Last <u>Fountain</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>11</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 8, 1887</u> | 9. AGE (In years lost birthday) <u>71</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>John Devore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Debbie Adams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>yes</u> | | 17. INFORMANT Address <u>Charles Fountain - Denton, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute myocardial infarction</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 1958 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>58</u> , to <u>8/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>58</u> , and that death occurred at <u>4:37 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Robert W. Trever</u> | | | | M.D. <u>Memorial Hospital, Easton</u> <u>8/12/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Aug 14 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Williams</u> ADDRESS <u>Federalburg, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>AUG 18 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

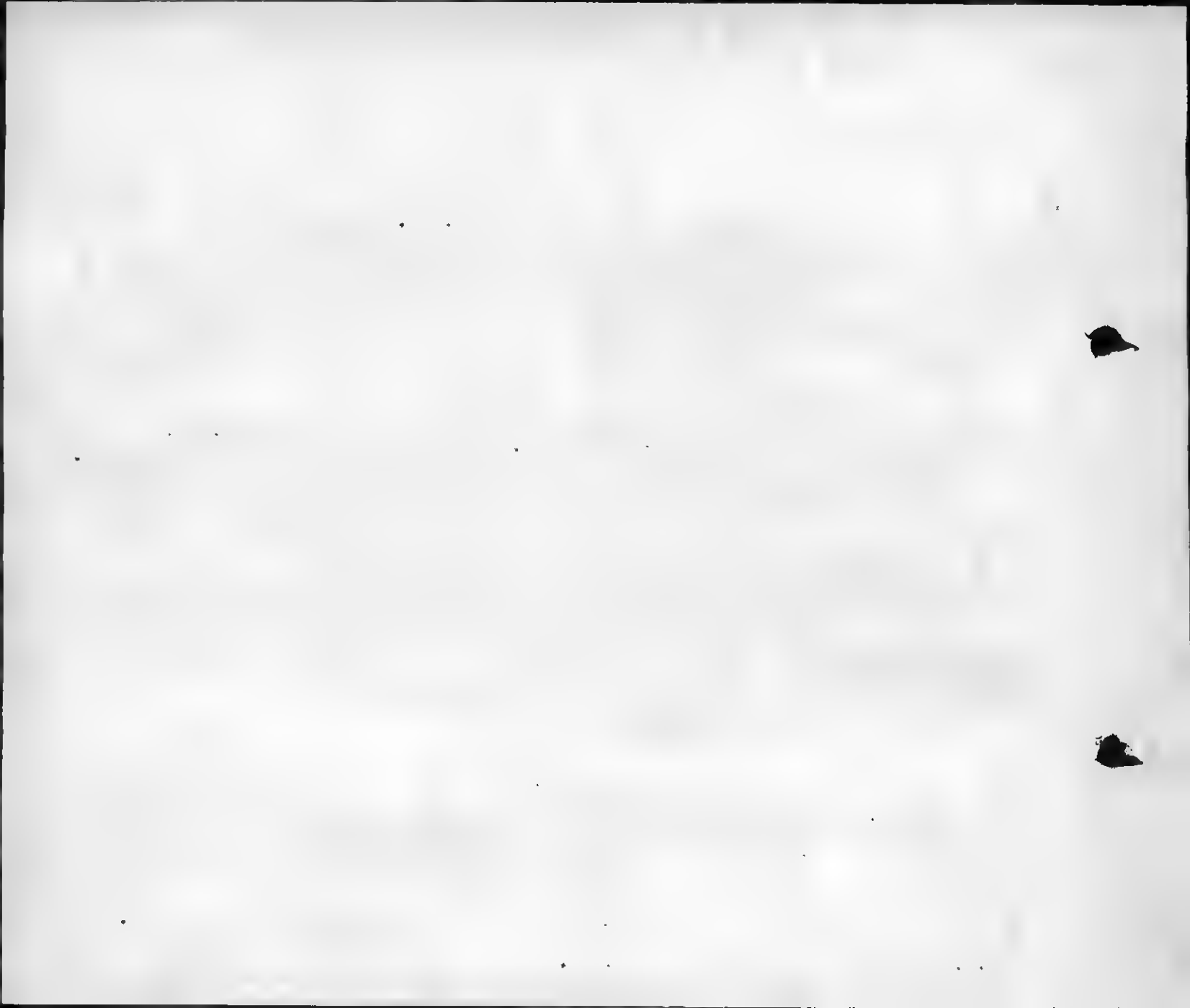
09503

Reg. Dist. No.

9510

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, putting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>REPT #1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> d. STREET ADDRESS <u>Montg. Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Maurice William Frizzell</u> First Middle Last 4. DATE OF DEATH <u>Aug. 1 1958</u> Month Day Year | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>11/14/11</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>46</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John C. Frizzell</u> 14. MOTHER'S MAIDEN NAME <u>Katherine Kempt</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war and dates of service) <u>WW2</u> 16. SOCIAL SECURITY NO <u>213-05-7354</u> 17. INFORMANT <u>Mrs. Elizabeth Frizzell</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Brain injuries</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Auto accident</u> DUE TO (c) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Car sideswiped by a motor</u> | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 22b. DATE THEREOF <u>8/4/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u> 22d. LOCATION (City, town, or county) <u>Elkridge</u> (State) <u>Md.</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. HIGINBOTHOM</u> <u>Ellicott City, Md.</u> 24a. REC'D BY REGISTRAR <u>Aug 6 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u> | |



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9527 CERTIFICATE OF DEATH

09504

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|---|-------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Stevensville</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>101-102 N. York St.</u> | | | | d. STREET ADDRESS <u>101-102 N. York St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>J. Steve Goodhand</u> | | | | 4. DATE OF DEATH <u>Aug. 7, 1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 7 1875</u> | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RURAL MAIL CARRIER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John F. Goodhand</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CAROLINE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>1-10-101010</u> | | 17. INFORMANT <u>Dr. Charles Goodhand</u> Address <u>Portersburg, W. Va.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction acute - mu dat</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary heart</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic cardiac failure</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>1-27-</u> , 19 <u>58</u> , to <u>8-6-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-6-</u> , 19 <u>58</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>St. Michaels Md</u> DATE SIGNED <u>8-8-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>Aug. 11, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u> ADDRESS <u>Easton, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>AUG 13 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | |



9511

Item 9 100-1003 2-1-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Salbit</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Salbit</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. LENGTH OF STAY IN 1b <u>8 mo.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47 Easton</u> | |
| | | d. STREET ADDRESS <u>1109 Park Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Alexander</u> Last <u>Green</u> | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1958</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 14, 1897</u> |
| 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR: Months <u>7</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>A. J. J. Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Joshua Green</u> | | 14. MOTHER'S MAIDEN NAME <u>Georgina Hepburn</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U. S. Army</u> | | 16. SOCIAL SECURITY NO. <u>087-07-8490</u> | |
| 17. INFORMANT <u>Rebecca D Green</u> | | Address <u>Easton Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>465x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pulmonary TBC</u> <u>Coronary atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1957</u> to <u>2000</u> , that I last saw the deceased alive on <u>28 Aug</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Rebecca D Green</u> M.D. | | DATE SIGNED <u>Sept 2, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>DR. RSTON</u> <u>442, 2150</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Sept 2, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lane Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rebecca D Green</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u> | |
| ADDRESS <u>Easton Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>Rebecca D Green</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

9512

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>HAMILTON</u> Last <u>HAMILTON</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1958</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 24, 1876</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>28</u> Hours <u>19</u> Min <u>58</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Himelwright</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Garrett</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give year or date of service)</u> | | 16. SOCIAL SECURITY NO. <u>Ruth Wharton St Michaels Md.</u> | |
| 17. INFORMANT <u>Ruth Wharton St Michaels Md.</u> | | Address <u>St Michaels Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>arteriosclerosis</u> DUE TO <u>arteriosclerosis</u> (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension - Essential</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>2-23</u> 19 <u>54</u> , to <u>8-28</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8-28</u> 19 <u>58</u> , and that death occurred at <u>7:25</u> A.M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>George H. Harrison</u> M.D. | | ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>8-28-58</u> | |
| PHYSICIAN'S NAME (Type) <u>George H. Harrison</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 22b. DATE THEREOF <u>Sept 30, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Michael's Harrison</u> ADDRESS <u>St. Michael's</u> | | 24a. REC'D BY REGISTRAR <u>SEP 2 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

09507

9513

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>130 West St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mrs. Stella</u> First Middle Last <u>Harrison</u> | | | | 4. DATE OF DEATH <u>August 30</u> 19 <u>58</u> Month Day Year | | | |
| 5. SEX <u>F.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec. 15, 1895</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | 10. UNDER 1 YEAR <u>62</u> Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME <u>Mr. George W. Greenwood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georgina Hynton</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO | | | |
| 17. INFORMANT <u>Arthur J. H. H.</u> Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of bowel</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>?</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 19, 58</u> to <u>8/30/58</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u>8/1/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>P. E. Cox</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>P. E. Cox</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. H. H.</u> ADDRESS <u>Easton Md</u> | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. H. H.</u> | |
| DATE <u>SEP 3 '58</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

9514

09508

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. LENGTH OF STAY IN 1b 7 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital | | | | d. STREET ADDRESS Denton RFD (Hobbs) | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Orem Haywood Henry | | | | 4. DATE OF DEATH Month Day Year August 31 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 1878 | 9. AGE (In years last birthday) yrs. 80 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James Henry | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Hypertensive C-V disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (?) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis of the pulmonary artery | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 25 Dec., 1958 , to 31 Aug., 1958 , that I last saw the deceased alive on 31 Aug., 1958 , and that death occurred at 2:10 a.m. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thorston Harrison M.D. | | | | ADDRESS (Street, city or town, state) Denton, Maryland DATE SIGNED 3 Sept 1958 | | | |
| PHYSICIAN'S NAME (Type) THORSTON HARRISON | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Sept 3 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Denton | | 22d. LOCATION (City, town, or county) (State) Denton Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore & Son | | | | ADDRESS Denton | | 24a. REC'D BY REGISTRAR DATE SEP 5 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Thomas | | | |

VS A15 (4)
15M 9/53



CERTIFICATE OF DEATH

09509

Reg. Dist. No.

9515

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| c. LENGTH OF STAY IN 1b <u>3 hrs</u> | | d. STREET ADDRESS <u>Easton Memorial Hospital</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Gardner</u> Middle <u>A.</u> Last <u>A. 99 yrs</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 27 1899 58 yrs</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Daniel E. Higgins</u> | | 14. MOTHER'S MAIDEN NAME <u>Augusta Godwin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 17. INFORMANT Address | |

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED While ☐ at work Not while ☐ at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:25 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

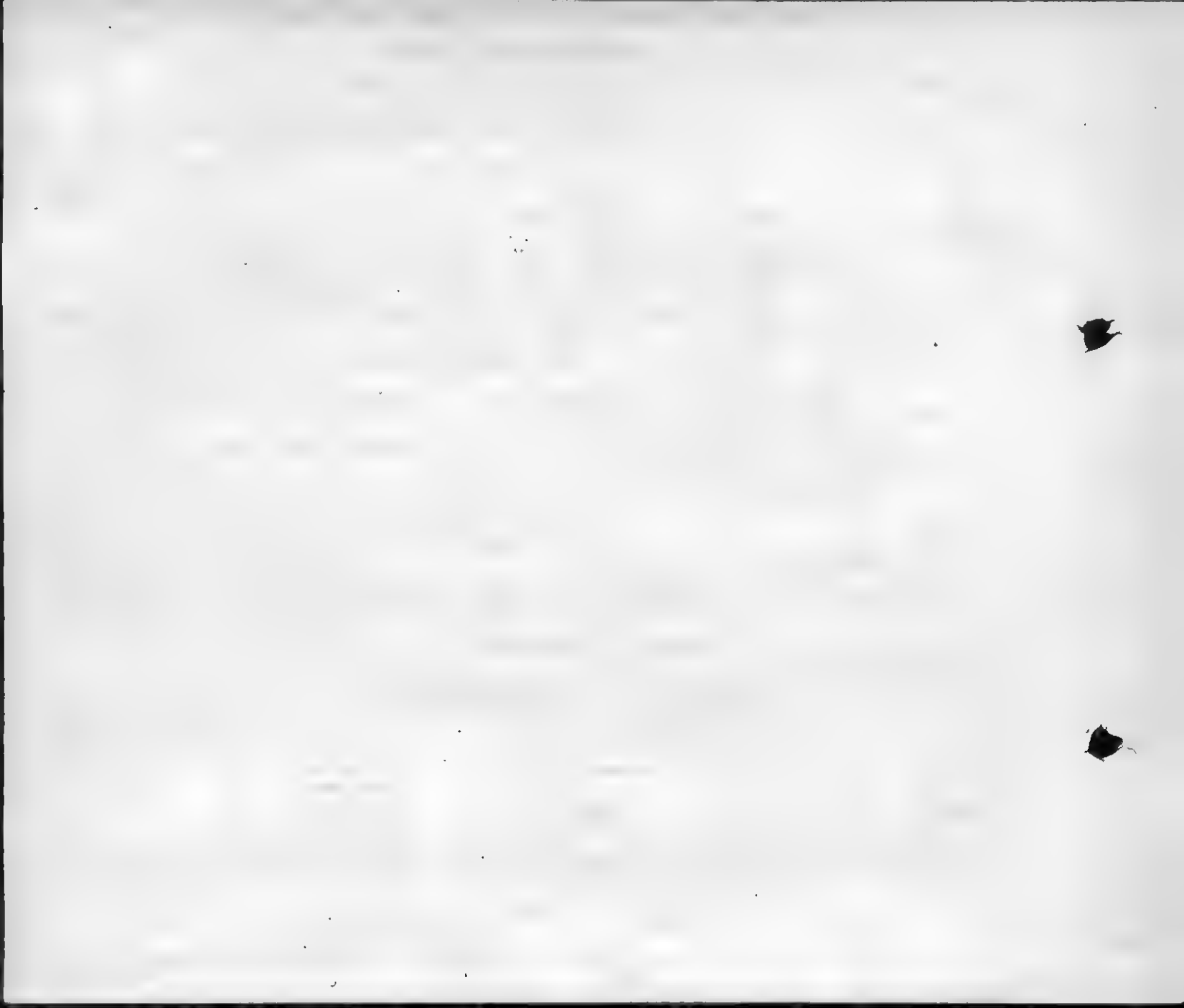
M.D.

PHYSICIAN'S NAME (Type)

| | | | |
|---|--------------------|------------------------------------|---|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>Aug 5, 1958</u> | <u>Oxford Cemetery</u> | <u>Oxford Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | |
| <u>W. Hamilton Harrison, St. Michaels</u> | | <u>Aug 12 1958</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |
| <u>St. Michaels</u> | | <u>Arthur L. Krusey</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9516

CERTIFICATE OF DEATH

09510

Reg. Dist. No.

| | | | |
|---|------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmanville</u> 1160 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Memorial Hospital</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby "B"</u> Middle <u>Johnson</u> Last | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 7, 1958</u> |
| 9. AGE (In years last birthday) yrs. <u>12</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Memorial Hosp Easton Md</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>John Johnson</u> | | 14. MOTHER'S MAIDEN NAME <u>Hilda Hammond</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>John Hammond Johnson</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelectasis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>12 hrs</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>58</u> , to <u>8/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/7</u> , 19 <u>58</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John E. Baylitt</u> M.D. | | DATE SIGNED <u>8-14-58</u> | |
| PHYSICIAN'S NAME (Type) | | ADDRESS (Street, city or town, state) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>8/11/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Removal Hospital Easton Md</u> | | 24. REC'D BY REGISTRAR <u>Aug 15 '58</u> | |
| 24a. REGISTRAR'S SIGNATURE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hance</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9528

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None | | | | d. STREET ADDRESS / | | | |
| 3. NAME OF DECEASED (Type or print) First Ollie Middle E. Last Marshall | | | | 4. DATE OF DEATH Month 8 Day 17 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 6-18-1912 | | 9. AGE (In years last birthday) 46 yrs. | IF UNDER 1 YEAR Months 46 | IF UNDER 24 HRS. Days 17 Hours 17 Min 17 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Crab & Oyster | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME John W. Marshall | | | | 14. MOTHER'S MAIDEN NAME Eva Moore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. 220-01-5957 | | 17. INFORMANT Mrs. Harrison Ross Address St. Michaels, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic alcoholic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958 to Aug 17, 1958 , that I last saw the deceased alive on 1958 , and that death occurred at 2A from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE CLY M REESER M.D. | | | | DATE SIGNED Aug 17 1958 | | | |
| PHYSICIAN'S NAME (Type) CLY M REESER | | | | ADDRESS TILGHMAN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8-19658 | | 22c. NAME OF CEMETERY OR CREMATORY Tilghman Methodist | | 22d. LOCATION (City, town, or county) (State) Tilghman Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert Moore Tilghman Md. | | | | 24a. REC'D BY REGISTRAR DATE: UG 21 '58 | | 24b. REGISTRAR'S SIGNATURE William S. Thomas | |

1. HOSPITAL ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove, carbon copy, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove, carry to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 ISM 9/55

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9517

CERTIFICATE OF DEATH

09511

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. LENGTH OF STAY IN 1b 3 hrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp. | | | | e. STREET ADDRESS 116 GLENWOOD AVENUE | | | |
| 3. NAME OF DECEASED (Type or print) First BOY Middle - Last McCLAIN | | | | 4. DATE OF DEATH Month August Day 26 Year 1958 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-26-58 | | 9. AGE (In years last birthday) yrs. 3 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME GEORGE David McCLAIN JR | | | | 14. MOTHER'S MAIDEN NAME FRANCES WINIFRED HARRISON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr George David McClain Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth (Wt 720 gms) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8/26/1958 to 8/26/1958 , that I last saw the deceased alive on 8/26/1958 , and that death occurred at 10 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE B. F. Cox | | | | DATE SIGNED 8/27/58 | | | |
| PHYSICIAN'S NAME (Type) B. F. Cox | | | | M. D. Easton Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremated | | 22b. DATE OF REMOVAL 8/28/58 | | 22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital | | 22d. LOCATION (City, town, or county) (State) Easton Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Harris | | | | 24a. REC'D BY REGISTRAR DATE SEP 3 '58 | | | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Harris | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9518

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09513

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD.</u> b. COUNTY <u>TALBOT</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSP.</u> | | e. STREET ADDRESS <u>RT. 1 Box 169</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Debra</u> Middle <u>ANN</u> Last <u>MONDAY</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 30-1958</u> |
| 9. AGE (In years last birthday) yrs. <u>2</u> | | 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CALVIN MILLER</u> | | 14. MOTHER'S MAIDEN NAME <u>EMMA G. MONDAY</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>-</u> | |
| 17. INFORMANT <u>MOTHER - RT. 1 Box 169 Easton, MD</u> | | Address <u>RT. 1 Box 169 Easton, MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 2# 23</u> DUE TO <u>Focal Cerelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>-</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>7 30, 1958</u> to <u>8 1, 1958</u> , that I last saw the deceased alive on <u>8-1, 1958</u> , and that death occurred at <u>MD</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>John E Baybutt</u> M.D. | | ADDRESS (Street, city or town, state) <u>205 Earle Ave Easton MD</u> | |
| PHYSICIAN'S NAME (Type) <u>JOHN E. BAYBUTT</u> | | DATE SIGNED <u>8-7-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Newtown cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Cordova MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shields</u> | | ADDRESS <u>Easton, MD</u> | |
| 24a. REC'D BY REGISTRAR <u>AUG 14 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Henshaw</u> | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9519

09514

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If inst. tuition: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boston</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boston</u> | |
| c. LENGTH OF STAY IN 1b <u>87 yrs</u> | | d. STREET ADDRESS <u>1 207 S Harrison</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>home</u> | | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Francis</u> First <u>Compton</u> Middle <u>Thomas</u> Last | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 30, 1870</u> |
| 9. AGE (in years last birthday) <u>87</u> | | 10. USUAL OCCUPATION (Give kind of work done, 100% KIND OF BUSINESS OR INDUSTRY) <u>Housekeeper</u> <u>Own Home</u> | |
| 11. BIRTH PLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>Dr. James H. Anderson</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth F. Chubb</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>8-19-36-7310</u> | |
| 17. INFORMANT <u>Carl B. Thomas</u> Address <u>Boston Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> | | | |
| 4 <u>years</u> DUE TO (b) <u>Generalized arteriosclerosis</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Lois R. Phitt</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>INFANT</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u> | | 22b. DATE THEREOF <u>Aug 5, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Boston Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Clark</u> Address <u>Boston</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. File pages 1, 2 and 3 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 and 3 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

10/21/1911

CERTIFICATE OF DEATH

Reg. Dist. No.

9520

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>Easton Memorial Hosp</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Nichols</u> Last <u>Nichols</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 13 1876</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>82</u> Days <u>82</u> Hours <u>82</u> Min. <u>82</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Sta. mcn Filling Station</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Anthony Nichols</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Jane</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT <u>Mr. E. Schmitt</u> Address <u>Trappe</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac dective & hyp. trophy</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerosis</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive at <u>Trappe</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>E. C. H. Schmitt</u> M.D. | | DATE SIGNED <u>29 5 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u> | | <u>Easton 16, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Aug 30, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William</u> ADDRESS <u>Trappe</u> | | 24a. REC'D BY REGISTRAR <u>SEP 3 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09518

9523

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

705
FOR STATE
HEALTH DEPT.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. LENGTH OF STAY IN 1b <u>3 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elizabeth</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u> | | | | d. STREET ADDRESS <u>250 BROADWAY</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Stanley</u> Last <u>Paulus</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>March 18, 1935</u> | |
| 9. AGE (In years last birthday) <u>23</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> | |
| 13. FATHER'S NAME <u>Stanley Paulus</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Helen Lausewieck</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK</u> | | 16. SOCIAL SECURITY NO. <u>1-57-267404</u> | | 17. INFORMANT <u>MR. STANLEY PAULUS, ELIZABETH, N.J.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull - motor cycle</u> DUE TO (b) <u>accident.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>821X</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>State highway</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>8/31/58</u> Hour <u>4:45</u> a. m. <u> </u> p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State highway</u> | | 20f. (City or town) <u>Linden</u> (County) <u>W. J.</u> (State) <u>Cal</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>W. Henry Fisher</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>8/31-58</u> | | | |
| NAME (Type) <u> </u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Spec. fy) <u>REMOVAL</u> | | 22b. DATE THEREOF <u>9/5/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ROSEHILL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>LINDEN N.J.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll</u> | | ADDRESS <u>Easton, Md.</u> | | 24a. REC'D BY REGISTRAR <u>SEP 9 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |



9521

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queen Anne 17</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <i>Roland</i> Middle <i>Pinkney</i> Last <i>Pinkney</i> | | 4. DATE OF DEATH Month <i>August</i> Day <i>19</i> Year <i>1958</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>C</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>May 7, 1907</i> |
| 9. AGE (In years lost birthday) <i>51</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | |
| 13. FATHER'S NAME <i>C. Charles Pinkney</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Flamer</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage, right</i> <i>446X</i> DUE TO <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Nephrosclerosis</i> (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>2:40 P</i> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>219 S. Washington St. Egoton 16, Maryland.</i> DATE SIGNED <i>20 Aug 58</i> | | | |
| ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> M.D. | | PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 24, 1958</i> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Sandtown</i> | | 22d. LOCATION (City, town, or county) (State) <i>Hebborn Ind.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Moore Son Denton</i> ADDRESS | | 24a. REC'D BY REGISTRAR DATE <i>AUG 28 '58</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Any use of this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached and use as the burial-transit permit. Then please remove carbon 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9522

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henderson | | | |
| c. LENGTH OF STAY IN TB 21 days | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp. | | | | d. STREET ADDRESS None | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Mr NORMAN First Middle Last Pippin | | | | 4. DATE OF DEATH Aug 20 19 58 Month Day Year | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/12/1879 | |
| | | | | 9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. less birthday) 79 yrs. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John O. Pippin | | | | 14. MOTHER'S MAIDEN NAME Mary Etta Lister | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Howard Pippin Henderson, Maryland Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x Apoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized arteriosclerosis DUE TO (c) ? | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7/31 1958 to 8/20 1958 , that I last saw the deceased alive on 8/20 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE P. E. Cox | | | | ADDRESS (Street, city or town, state) EASTON MARYLAND DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) DR. P. E. COX | | | | EASTON, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Aug 15 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Greensboro | | 22d. LOCATION (City, town, or county) (State) Greensboro Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Hawkins ADDRESS Greensboro Md | | | | 24a. REC'D BY REGISTRAR AUG 25 '58 DATE | | 24b. REGISTRAR'S SIGNATURE Carlton S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carefully the registrars' names, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

9529

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>116 E. Chestnut St</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>W.</u> Middle <u>Radcliffe</u> Last | | 4. DATE OF DEATH <u>Aug</u> Month <u>6</u> Day <u>1958</u> Year | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 8, 1883</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AGED FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS, Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>J. HARRY RADCLIFFE</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNIE E. BLADES</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>22-23-0972</u> | |
| 17. INFORMANT <u>Mrs Mary R. Radcliffe</u> Address <u>St. Michaels</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Hypertensive Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yr.</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>3 July</u> , 19 <u>58</u> , to <u>6 Aug</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 Aug</u> , 19 <u>58</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>R. Radcliffe</u> M.D. | | ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u> DATE SIGNED <u>8-7-58</u> | |
| NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>Aug 8, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Hovine</u> ADDRESS <u>St. Michaels, Md</u> | | 24a. REC'D BY REGISTRAR <u>Aug 12 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hovine</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached and used as the burial transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 #11-233 9-2-51 et

Reg. Dist No.

09520

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton ELKTON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Ann Elizabeth Rumbler</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 12 1925</u> 35 yrs |
| 9. AGE (In years last birthday) <u>33</u> yrs | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Spain Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Clarence Carlow</u> | | 14. MOTHER'S MAIDEN NAME <u>Hatter Kemp</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>Tara Al. Russell, Denton, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>X</u> (c) <u>due to the underlying cause lost.</u> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr, 40 min.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>FALL - AUTO ACCIDENT</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> p.m. <u>8-23-58</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u> | 20f. (City or town) (County) (State) <u>DENTON CAROLINE MD.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Hanson O George</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>DANSON O George</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>Aug 27/1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> | | 22d. LOCATION (City, town, or county) (State) <u>Denton</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Hoover Son</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>AUG 28 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u> | |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. Fill pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9525

Reg. Dist. No.

09521

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edwards</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u> | | e. STREET ADDRESS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Randy</u> Middle <u>Thomas</u> Last <u>Russell</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9. AGE (In years, last birthday) <u>—</u> yrs <u>11</u> Months <u>11</u> Days <u>—</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Mr. Thomas Russell</u> | | 14. MOTHER'S MAIDEN NAME <u>Ann Corkran</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Wm. O. Russell, Jr., Ind.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>8-24-58</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 404</u> | 20f. (City or town) (County) (State) <u>Rural Denton Caroline Md</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Dawson E. George</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>DAWSON E. GEORGE</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. DATE THEREOF <u>Aug. 27/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u> | |
| 22b. LOCATION (City, town, or county) (State) <u>Denton Ind.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Denton Ind.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Moore</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u> | |
| ADDRESS <u>Denton</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09522

Reg. Dist. No.

9526

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. LENGTH OF STAY IN 1b 12 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS S. Washington | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) William Edward Sharp, Sr. | | | | 4. DATE OF DEATH Aug 25, 1958 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 24, 1874 | |
| 9. AGE (In years (last birthday)) 84 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 11. BIRTHPLACE (State or foreign country) Talbot C. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Daniel Sharp | | | | 14. MOTHER'S MAIDEN NAME Mary Rebecca Shortall | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT William Edward Sharp, Jr. Easton | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1948 , 19____, to 8/25/58 , that I last saw the deceased alive on 8/24/58 , 19____, and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 8/25/58 ACTUAL SIGNATURE P.F. Cox M.D. PHYSICIAN'S NAME (Type) P.F. Cox | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Aug 27, 58 | | Spring Hill | | Easton, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thoms | | | | 24a. REC'D BY REGISTRAR DATE AUG 28 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Thoms | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

8115 21-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for use as the burial-transit permit. Then please remove card and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9530

CERTIFICATE OF DEATH

Reg. Dist. No. 09523

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cardross</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cardross</u> | |
| c. LENGTH OF STAY IN 1b <u>75 yrs</u> | | d. STREET ADDRESS <u></u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Romas</u> Last <u>Shawood</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 2 1887</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs. | | IF UNDER 1 YEAR: Months <u>9</u> Days <u>8</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Farm</u> | |
| 11. BIRTHPLACE (State of foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>William Shawood</u> | | 14. MOTHER'S MAIDEN NAME <u>Ella Lannor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-24-4236</u> | |
| 17. INFORMANT <u>Mrs Wm Romas Shawood Cardross</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from _____, 19____, to <u>Aug 10</u> , 19 <u>58</u> that I last saw the deceased alive on _____, 19____, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. Henry Fisher</u> M.D. | | ADDRESS (Street, city or town, state) <u>Centerville Md</u> DATE SIGNED <u>8/12-58</u> | |
| PHYSICIAN'S NAME (Type) _____ | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Aug 13, 58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u> | 22d. LOCATION (City, town, or county) (State) <u>Cardross Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knud</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 14 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knud</u> |

